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IN THE
Supreme Court of the United States
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STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D.,
ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and
PETER SHALIT, M.D., PH.D.,
Respondents.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF OF RESPONDENTS

Of Counsel

Laurence H. Tribe
Hauser Hall 420
1575 Massachusetts Avenue
Cambridge, MA 02138
(617) 495-4621

Kathryn L. Tucker
Counsel of Record

David J. Burman
Kari Anne Smith
PERKINS COIE
1201 Third Avenue, 40th Fl.
Seattle, WA 98101-3099
(206) 583-8888

Attorneys for Respondents

QUESTIONS PRESENTED

Whether the Fourteenth Amendment's guarantee of liberty protects the decision of a mentally competent, terminally ill adult to bring about impending death in a certain, humane, and dignified manner?

Whether a state denies equal protection when it permits terminally ill patients who are on life support to choose a humane death with medical assistance but prohibits terminally ill patients who are not on life support from exercising the same right by self-administering medication prescribed for that purpose?

CONTENTS

| | <i>Page</i> |
|--|-------------|
| QUESTIONS PRESENTED | i |
| OPINIONS BELOW | 1 |
| JURISDICTION | 1 |
| CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED | 1 |
| STATEMENT OF THE CASE | 1 |
| SUMMARY OF ARGUMENT | 7 |
| I. INDIVIDUAL LIBERTY PROTECTED BY THE FOURTEENTH AMENDMENT INCLUDES CONTROL OF ONE'S FINAL DAYS | 7 |
| II. DENYING ASSISTANCE IN DYING TO TERMINALLY ILL PATIENTS NOT ON LIFE SUPPORT VIOLATES EQUAL PROTECTION | 7 |
| ARGUMENT | 8 |
| I. THE CHALLENGED STATUTE INFRINGES THE LIBERTY OF COMPETENT, TERMINALLY ILL ADULTS TO MAKE END-OF-LIFE DECISIONS FREE OF UNDUE GOVERNMENT INTERFERENCE | 10 |
| A. A Competent, Terminally Ill Patient's End-of-Life Decision Is Within the Court's Interpretation of Liberty as Including Basic and Intimate Exercises of Personal Autonomy | 10 |

| | |
|---|----|
| B. The Liberty to Direct the Withdrawal of Medical Treatment to Hasten Death Is No Different Than That in Choosing to Hasten Impending Death With Medications Prescribed For That Purpose | 22 |
| C. The Challenged Statute Does Not Serve Legitimate State Interests; State Regulation Would Better Protect Any Such Interests | 28 |
| 1. The Challenged Statute Is Not Necessary to Protect Against Third-Party Usurpation of the Patient's Control Over the Remaining Days of Life | 30 |
| 2. Ensuring That Assistance Is Provided Only to Mentally Competent, Uncoerced, Terminally Ill Patients Better Protects the State's Interests Than Does the Current Covert Practice | 32 |
| (a) Prohibiting All Competent, Uncoerced, Terminally Ill Patients From Exercising a Right to Protect a Few Incompetent or Coerced Patients From Erroneously Exercising That Right Does Not Serve Any State Interest | 32 |
| (b) Terminal Illness Is a Workable Boundary | 34 |

| | |
|---|----|
| (c) The Random, Covert, and Unregulated Practice Under the Existing Prohibition Poses Greater Risk to the State's Interests | 38 |
| 3. Federalism Does Not Justify Unlimited Government Power at the Expense of Individual Autonomy | 39 |
| II. SECTION 9A.36.060 DENIES EQUAL PRO- TECTION TO COMPETENT, TERMINALLY ILL ADULTS WHO ARE NOT ON LIFE SUPPORT | 42 |
| CONCLUSION | 47 |

TABLE OF AUTHORITIES

| | <i>Page</i> |
|--|--------------|
| Cases | |
| <i>Akron v. Akron Ctr. for Reprod. Health</i> , 462 U.S. 416 (1983) | 28 |
| <i>Bowers v. Hardwick</i> , 478 U.S. 186 (1986)..... | 16 |
| <i>Carey v. Population Services International</i> , 431 U.S. 678 (1977) | 11, 20 |
| <i>Compassion in Dying v. Washington</i> , 79 F.3d 790 (CA9 1996) (en banc)..... | passim |
| <i>Compassion in Dying v. Washington</i> , 850 F. Supp. 1454 (W.D. Wash. 1994)..... | 4, 6, 33, 46 |
| <i>Cruzan v. Director, Mo. Dep't of Health</i> , 497 U.S. 261 (1990) | passim |
| <i>Eisenstadt v. Baird</i> , 405 U.S. 438 (1972)..... | 11, 20 |
| <i>Faretta v. California</i> , 422 U.S. 806 (1975) | 34 |
| <i>Griswold v. Connecticut</i> , 381 U.S. 479 (1965) | 10, 11, 20 |
| <i>In re Conroy</i> , 486 A.2d 1209 (N.J. 1985)..... | 18 |
| <i>In re Gardner</i> , 534 A.2d 947 (Me. 1987) | 18 |
| <i>In re Guardianship of Grant</i> , 109 Wash. 2d 545, 747 P.2d 445 (1987) | 18, 42 |
| <i>In re Guardianship of Hamlin</i> , 102 Wash. 2d 810, 689 P.2d 1372 (1984)..... | 18, 42 |

| | |
|---|----------------|
| <i>In re Quinlan</i> , 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976)..... | 31 |
| <i>In re Welfare of Colyer</i> , 99 Wash. 2d 114, 660 P.2d 738 (1983)..... | passim |
| <i>Loving v. Virginia</i> , 388 U.S. 1 (1967)..... | 11 |
| <i>Maher v. Roe</i> , 432 U.S. 464 (1977)..... | 28 |
| <i>Meyer v. Nebraska</i> , 262 U.S. 390 (1923) | 11, 29 |
| <i>Moore v. East Cleveland</i> , 431 U.S. 494 (1977) | 11, 12 |
| <i>Pierce v. Society of Sisters</i> , 268 U.S. 510 (1925)..... | 11 |
| <i>Planned Parenthood v. Casey</i> , 505 U.S. 833 (1992)..... | passim |
| <i>Planned Parenthood of Mo. v. Danforth</i> , 428 U.S. 52 (1976)..... | 4 |
| <i>Poe v. Ullman</i> , 367 U.S. 497 (1961) | 10, 19 |
| <i>Quill v. Vacco</i> , 80 F.3d 716 (CA2), cert. granted, No. 95-1858 (1996) | passim |
| <i>Rochin v. California</i> , 342 U.S. 165 (1952)..... | 10, 12, 17, 40 |
| <i>Roe v. Wade</i> , 410 U.S. 113 (1973)..... | passim |
| <i>Romer v. Evans</i> , 134 L. Ed. 2d 855 (1996)..... | 29 |
| <i>Schweiker v. Wilson</i> , 450 U.S. 221 (1981)..... | 41 |
| <i>Skinner v. Oklahoma ex rel. Williamson</i> , 316 U.S. 535 (1942) | 11 |
| <i>Smith v. Cote</i> , 513 A.2d 341 (N.H. 1986)..... | 26 |

| | |
|---|------------|
| <i>Snyder v. Massachusetts</i> , 291 U.S. 97 (1934)..... | 24 |
| <i>State v. Jamison</i> , 94 Wash. 2d 663, 619 P.2d 352 (1980)..... | 8 |
| <i>Superintendent of Belchertown State Sch. v. Saikewicz</i> , 370 N.E.2d 417 (Mass. 1977)..... | 32 |
| <i>Thornburgh v. American College of Obstetri- cians & Gynecologists</i> , 476 U.S. 747 (1986)..... | 37 |
| <i>United States v. Virginia</i> , 116 S. Ct. 2264 (U.S. 1996)..... | 16 |
| <i>Washington v. Confederated Bands & Tribes of Yakima Indian Nation</i> , 439 U.S. 463 (1979)..... | 42 |
| <i>Washington v. Harper</i> , 494 U.S. 210 (1990) | 11, 17, 33 |
| <i>West Virginia Bd. of Educ. v. Barnette</i> , 319 U.S. 624 (1943) | 41 |
| <i>Winston v. Lee</i> , 470 U.S. 753 (1985)..... | 12 |
| <i>Wooley v. Maynard</i> , 430 U.S. 705 (1977) | 41 |
| Statutes | |
| 42 U.S.C. 1395x(dd)(3)(A) | 35 |
| Cal. Health & Safety Code § 7186(j) | 35 |
| Pub. L. No. 104-204, Newborns' and Mothers' Health Protection Act of 1996 | 34 |
| Wash. Rev. Code § 9A.36.060 | passim |
| Wash. Rev. Code § 70.122.030(2)..... | 29 |

| | |
|--|-----------|
| Wash. Rev. Code § 70.122.010 | passim |
| Wash. Rev. Code § 70.122.020(8)..... | 29 |
| Wash. Rev. Code § 70.122.020(8)-(9)..... | 35 |
| Wash. Rev. Code § 70.122.030 | 43 |
| Wash. Rev. Code § 70.122.051 | 1, 30, 43 |
| Wash. Rev. Code § 70.122.060(4)..... | 26 |
| Wash. Rev. Code § 70.122.080 | 9 |
| Wash. Rev. Code § 70.122.910 | 43 |

Other Authorities

| | |
|---|--------|
| Aries, Philippe, <i>The Hour of Our Death</i> 569 (1981)..... | 39 |
| Back, Anthony L. et al., <i>Physician-Assisted Suicide and Euthanasia in Washington State</i> , 275 JAMA 919 (1996) | 27, 38 |
| Becker, Ernest, <i>The Denial of Death</i> (1973)..... | 39 |
| Brody, Howard, <i>Assisted Death — A Compas- sionate Response to a Medical Failure</i> , 327 New Eng. J. Med. 1384 (1992) | 9 |
| CeloCruz, Maria T., <i>Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?</i> , 18 Am. J.L. & Med. 369 (1992)..... | 18 |
| Charmaz, Kathy, <i>The Social Reality of Death</i> (1980)..... | 39 |

| | |
|--|----|
| Chernoy, Nathan et al., <i>Sedation in the Manage- ment of Refractory Symptoms: Guidelines for Evaluation and Treatment</i> , 10 J. of Palliative Care 31 (1994)..... | 21 |
| Cohen, Jonathan S., et al., <i>Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State</i> , 331 New Eng. J. Med. 89 (1994)..... | 26 |
| Cork, R., et al., <i>Is There Implicit Memory After Propofol Sedation?</i> , 76 Brit. J. Anaesthesia 492 (1996) | 22 |
| Farnsworth, Clyde H., <i>Bungled AIDS Suicides Often Increase the Suffering</i> , N.Y. Times, June 14, 1994, at B9..... | 27 |
| Forster, Lorna E. & Lynn, Joanne, <i>Predicting Life-Span for Applicants to Inpatient Hospice</i> , 148 Archives of Internal Med. 2540 (1988) | 36 |
| Ginsburg, Ruth B., <i>Speaking in a Judicial Voice</i> , 67 N.Y.U. L. Rev. 1185 (1992)..... | 40 |
| Harmon, Louise, <i>Fragments on the Deathwatch</i> , 77 Minn. L. Rev. 1 (1992)..... | 39 |
| Knox, Richard, A., <i>1 in 5 Doctors Say They Assisted a Patient's Death, Survey Finds</i> , Boston Globe, Feb. 28, 1992, at 5 | 38 |
| Lee, Melinda A., <i>Legalizing Assisted Suicide — Views of Physicians in Oregon</i> , 334 New Eng. J. Med. 310 (1996)..... | 26 |

| | |
|---|------------|
| Miller, Franklin G., et al., <i>Regulating Physician-Assisted Death</i> , 331 New Eng. J. Med. 119 (1994) | 26, 38, 41 |
| Moerman, N., et al., <i>Awareness and Recall During General Anesthesia</i> , 79 Anesthesiology 454 (1993) | 22 |
| Nuland, Sherwin B., <i>How We Die: Reflections on Life's Final Chapter</i> (1993) | 5, 27, 38 |
| O'Connor, Sandra D., <i>Conference on Compelling Government Interests</i> , 55 Alb. L. Rev. 535 (1992) | 16 |
| Ogden, Russel D., <i>Euthanasia, Assisted Suicide & AIDS</i> (1994) | 27 |
| Phipps, William E., <i>Death: Confronting the Reality</i> (1987) | 39 |
| Previn, Matthew P., <i>Assisted Suicide and Religion, Conflicting Conceptions of the Sanctity of Human Life</i> , 84 Geo. L.J. 589 (1996) | 19 |
| Quill, Timothy E., <i>A Midwife Through the Dying Process</i> (1996) | 5 |
| Quill, Timothy E., <i>Death and Dignity</i> (1993) | 5 |
| Reuben, David B. et al., <i>Clinical Symptoms and Length of Survival in Patients With Terminal Cancer</i> , 148 Archives of Internal Med. 1586 (1988) | 36 |
| Rollin, Betty, <i>Last Wish</i> (1996) | 5 |

| | |
|---|--------|
| Rousseau, Paul, <i>Terminal Sedation in the Care of Dying Patients</i> , 156 Archives of Internal Med. 1785 (1996) | 26, 35 |
| Rubinfeld, Jed, <i>The Right of Privacy</i> , 102 Harv. L. Rev. 737 (1989) | 14 |
| Shavelson, Lonny, <i>A Chosen Death</i> (1995) | 5 |
| <i>Special Reports from the Netherlands</i> , 335 New Eng. J. Med. 1676 (1996) | 36 |
| Strasser, Mark, <i>Assisted Suicide and the Competent Terminally Ill</i> , 74 Or. L. Rev. 539 (1995) | 32, 39 |
| Truog, Robert D. et al., <i>Barbiturates in the Care of the Terminally Ill</i> , 327 New Eng. J. Med. 1678 (1992) | 21 |
| Wanzer, Sidney H. et al., <i>The Physician's Responsibility Toward Hopelessly Ill Patients, A Second Look</i> , 320 New Eng. J. Med. 844 (1989) | 38 |

OPINIONS BELOW

Respondents concur in petitioners' statement.

JURISDICTION

Respondents concur in petitioners' statement.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Respondents concur in petitioners' statement.

STATEMENT OF THE CASE

The State of Washington has recognized a "fundamental right" of a competent, terminally ill patient to exercise "individual autonomy" to end a painful, dehumanizing, and extended process of dying. Wash. Rev. Code § 70.122.010. To that end, the State has made lawful the withdrawal of medical treatment and hydration and nutrition for the purpose of hastening death at the request of such patients. Wash. Rev. Code § 70.122.051. A preexisting state law, however, makes it a crime to aid another person to attempt suicide. Wash. Rev. Code § 9A.36.060. This law applies to physicians who respond to a mentally competent, terminally ill patient's choice to avoid an extended course of dying by prescribing medications that the patient can choose to take to bring about impending death. This case challenges that application as a denial of liberty and of equal protection.

The record establishes these undisputed facts regarding the plaintiff patients and physicians:

At the time the complaint was filed, the plaintiff who used the pseudonym Jane Roe was dying of breast cancer.¹ She was 69, a retired pediatrician. Her cancer had metastasized widely and was growing rapidly throughout her entire skeleton. She had undergone surgery, chemotherapy, and radiation therapy, but the cancer prevailed. Dr. Roe suffered chronic, intractable pain, which she attempted to alleviate with large and increasing doses of morphine. She still experienced frequent and severe pain. Dr. Roe was confined to bed for the seven months prior to the filing of this action. Movement was intensely painful, and her weakened muscles could not support her. She was anemic, incontinent, and vulnerable to infection.

Dr. Roe was mentally competent. She had been advised and, as a doctor, fully understood that there was no chance of recovery and that, despite excellent medical care, she faced severe and unrelenting suffering. Dr. Roe wished to hasten her impending death by taking drugs of a type and in an amount prescribed by her doctor for that purpose. *Compassion in Dying v. Washington*, 79 F.3d 790, 794-95 (CA9 1996) (en banc); Appendix to Petition for Writ of Certiorari (Pet. App.) A-10 to A-13. (The undisputed declarations of the patients and doctors appear in the Joint Appendix (JA) 22-75 and 187-228.)

Plaintiff John Doe, 44, was dying of AIDS. His doctors had advised him that there was no chance of recovery and that

¹ Dr. Roe died a month after the filing of the lawsuit, and the other two patient-plaintiffs died within the following months. See *Compassion in Dying v. Washington*, 79 F.3d 790, 794-95 (CA9 1996) (en banc); Appendix to Petition for Writ of Certiorari (Pet. App.) A-10 to A-13.

he faced severe and continuous suffering. Mr. Doe was vulnerable to all manner of infection. He had cytomegalovirus retinitis, which had caused him to lose approximately 70 percent of his vision and was anticipated to soon result in complete blindness. Mr. Doe had been hospitalized for AIDS-related pneumonia on several occasions; suffered from chronic skin infections, sinusitis, and grand mal seizures related to AIDS; and experienced extreme fatigue and a rapidly diminishing ability to care for himself. Mr. Doe had served as the primary caregiver for his long-term companion who died of AIDS at home. Mr. Doe witnessed firsthand the pain, suffering, and loss of bodily function, integrity, and personal dignity that the disease causes at the end of life.

Mr. Doe was mentally competent and understood his diagnosis and prognosis. He wished to hasten his impending death by taking drugs prescribed by his doctor. *Id.*

Plaintiff James Poe, 69, was dying of emphysema. His doctors had advised him that he had no chance of recovery. Every breath was a struggle. He was tethered to an oxygen tube 24 hours a day. He spent hours each day aspirating medications to facilitate breathing. He was terrified by his "constant sensation of suffocation." He regularly took morphine and other medications to calm his "terror." He also suffered from associated heart failure, which resulted in painful swelling of his extremities and loss of mobility. "The only comfortable times are when I am asleep. However, I have difficulty sleeping longer than two to three hours at a time." JA 30.

Mr. Poe was mentally competent and understood his diagnosis and prognosis. He too desired the right to hasten his impending death by taking drugs prescribed by his doctor for that purpose when his suffering became unbearable. 79 F.3d at 794-95; Pet. App. A-10 to A-13.

Respondents Glucksberg, Halperin, Preston, and Shalit are physicians who regularly treat terminally ill patients. Each encounters mentally competent, terminally ill patients who understand their condition, diagnosis, and prognosis and who desire physician assistance in dying to avoid prolonged suffering. Each feels a professional responsibility to honor a competent, voluntary, and personal choice in the face of death to hasten that death and reduce suffering. The physicians present both their own claims and the claims of their patients.² *Id.*

In the physicians' professional judgment, the desire of such patients to hasten impending death and avoid continued suffering can be rational. Each physician-plaintiff believes that before prescribing drugs that the patient could choose whether to take to bring about death, the appropriate procedure is to ensure that the patient is competent, is acting voluntarily, and is in the terminal phase of illness. Where this has been done and the patient still seeks a humane and dignified death, these doctors wish to prescribe drugs that will allow the patient to decide whether to live, and suffer, any longer. It was undisputed below that patients who cannot receive this medical assistance cannot hasten their deaths in a certain and humane manner and that some cannot hasten their death in any manner without such assistance. The physicians, however, know that prescribing drugs for this purpose exposes them to criminal prosecution under Wash. Rev. Code § 9A.36.060. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1457-58 (W.D. Wash. 1994); Pet. App. E-4 to E-7.

² The State does not challenge the Ninth Circuit's holding that the physicians, who sued on their own behalf and on behalf of their mentally competent, terminally ill patients, have standing to present the claims of such patients. 79 F.3d at 795-96; Pet. App. A-13 to A-15; see, e.g., *Planned Parenthood of Mo. v. Danforth*, 428 U.S. 52, 62 (1976).

As a result, the physicians have witnessed their patients suffer terrible ordeals. One of Dr. Glucksberg's mentally competent, terminally ill patients, who was in excruciating pain and did not want to end his days in a lingering drug-induced stupor, requested medication he could self-administer to hasten his impending death. Constrained by the criminal statute, Dr. Glucksberg was forced to refuse this request. The patient enlisted one of his family members to help him climb over a bridge railing to jump to his death. JA 35-36.

A competent patient of Dr. Halperin's with advanced terminal breast cancer, who had been fiercely self-sufficient throughout her lifetime, and who rejected living her final days in a dependent and undignified manner, requested medications she could take to hasten her death. Dr. Halperin was forced to reject this request. The patient suffocated herself by securing a plastic bag over her head. JA 50-51.

A mentally competent AIDS patient requested Dr. Shalit to prescribe medications he could self-administer to hasten a more gentle death. The criminal prohibition forced Dr. Shalit to deny the request and to stand by as the patient endured an excruciating and lingering death. Oozing lesions from his cancer prevented him from walking or urinating. His fingers were gangrenous. The patient's loved ones found his condition so horrifying that they could not bear to visit and witness his physical torture. JA 74-75.³

³ The experiences of these patients are in no way unique. The Brief Amici Curiae of Surviving Family Members in Support of Respondents details similar experiences. See also Timothy E. Quill, *Death and Dignity* (1993); Timothy E. Quill, *A Midwife Through the Dying Process* (1996); Lonny Shavelson, *A Chosen Death* (1995); Betty Rollin, *Last Wish* (1996); Sherwin B. Nuland, *How We Die: Reflections on Life's Final Chapter* (1993).

These patients and physicians were not "hypothetical," *cf.* Brief for the Petitioners at 39,⁴ and they filed suit in the United States District Court for the Western District of Washington, challenging the application of Section 9A.36.060 to them. On cross motions for summary judgment, with the State accepting all of plaintiffs' factual allegations, the District Court held that Section 9A.36.060 abridges rights secured by the United States Constitution, specifically liberty and equal protection guaranteed by the Fourteenth Amendment. 850 F. Supp. at 1467; Pet. App. E-28 to E-29. The Ninth Circuit, sitting en banc, affirmed the liberty analysis in an exhaustive opinion joined by eight judges. 79 F.3d at 813-16; Pet. App. A-56 to A-62. The Ninth Circuit did not reach the equal protection claim. *Id.* at 838; Pet. App. A-115. One month later, the Second Circuit invalidated similar application of a New York statute on equal protection grounds. *Quill v. Vacco*, 80 F.3d 716, 727 (CA2), *cert. granted*, No. 95-1858 (1996).

⁴ Petitioners never suggested below that these patients were less than real and never contested their conditions or the ability of their doctors to accurately assess whether they were in the terminal stage and whether they were competent. The challenged statute operated to prevent patient-plaintiffs Roe, Doe, and Poe — and operates to prevent the mentally competent, terminally ill patients of the physician-plaintiffs — from exercising the option of a humane, hastened death. Having found the statute unconstitutional as applied to these individuals, the court below properly concluded that the constitutional infirmity would exist as well in the case of individuals similarly situated. 79 F.3d at 798 n.9; Pet. App. A-20 to A-21.

SUMMARY OF ARGUMENT

I. INDIVIDUAL LIBERTY PROTECTED BY THE FOURTEENTH AMENDMENT INCLUDES CONTROL OF ONE'S FINAL DAYS

The Court has consistently recognized that the guarantee of liberty in the Fourteenth Amendment extends to life-shaping decisions that individuals make about their bodies and futures. Forcing a patient to suffer through an extended process of dying controls that person's remaining life and denies the patient's choice to cross the threshold of death in a manner consistent with her conscience and values. The State ought not intrude into and dictate this profoundly personal decision, forcing the patient-plaintiffs to endure painful and undignified deaths.

The State enforces an absolute prohibition on patient choice in a context where the State's legitimate concerns would be adequately, indeed better, addressed through regulation. Recognizing a dying patient's liberty to choose how to die in no way suggests that the State lacks a valid interest in protecting against usurpation of the dying patient's wishes by others. To say that the State must respect the individual's autonomy does not imply that the State must stand by while others try to extinguish such autonomy or that the State must allow an incompetent or coerced patient to die. The State may establish reasonable safeguards to assure that the patient is competent and has in fact reached the terminal phase of illness.

II. DENYING ASSISTANCE IN DYING TO TERMINALLY ILL PATIENTS NOT ON LIFE SUPPORT VIOLATES EQUAL PROTECTION

Washington law recognizes the same right at issue in this case, but only for a certain class of mentally competent, terminally ill patients — those whose lives depend upon contin-

ued medical intervention. Physicians who comply with requests by terminally ill patients to withdraw treatment, even where the patient's express intention is thereby to hasten death, are immune from prosecution under the challenged statute. Some terminally ill patients thus are able to choose to hasten impending death with medical assistance. This discrimination between terminally ill patients whose condition involves life-sustaining treatment and those whose condition does not involve such treatment violates the Equal Protection Clause of the Fourteenth Amendment.

ARGUMENT

Wash. Rev. Code § 9A.36.060 was enacted in 1854. It provides in relevant part that a person is guilty of a crime if he or she "knowingly . . . aids another person to attempt suicide."⁵ The Washington Supreme Court and the Washington

⁵ Respondents do not challenge the portion of the statute that prohibits "knowingly caus[ing] another person to attempt suicide," which would include undue influence or assisting in the suicide of a patient who was not mentally competent or who was known to be under a misapprehension as to such material facts as diagnosis and prognosis. See, e.g., *State v. Jamison*, 94 Wash. 2d 663, 619 P.2d 352 (1980) (defendant promoted suicide by abusing cellmate). Some amici urge that the challenged statute does not reach the conduct of a physician in prescribing medications for a competent, dying patient to use to hasten death. E.g., Brief Amici Curiae of Bioethicists in Support of Petitioners at 15 n.6. The State obviously disagrees and has expressed its intent to prosecute, thus deterring physicians from responding to the requests of these patients. It is true that the State has, in the name of federalism, claimed various purposes nowhere mentioned by the Washington Legislature and contrary to the legislative findings in Wash. Rev. Code § 70.122.010 and the Washington court decisions that preceded that statute. It should not be assumed that the State, as opposed to state lawyers, accepts those interests or finds that they outweigh the liberty at stake. For these reasons, Judge Calabresi in *Quill* suggested in his concurrence that a sensible course would be to strike the statute down as

Legislature have created effective exceptions to Section 9A.36.060 for those on life-sustaining treatment. Section 70.122.080 created an exception for withdrawal of life support, and in Section 70.122.010 the Legislature recognized the fundamental rights at issue here. Nonetheless, the State contends that the statute reaches physicians who respond to the requests of their competent, dying patients by prescribing drugs that the patients can use, when and if they so choose, to shape and control their imminent and inevitable death.

Since 1854, the art and science of medicine have advanced dramatically. Lifespans have been extended, and the dying process frequently proceeds less rapidly than once was the case.⁶ A series of court decisions and statutes permit competent patients undergoing an intolerable process of dying to direct the termination of life support, and thereby hasten death. Other patients, similarly facing imminent death, have conditions that are not susceptible to such treatments, and thus to the termination of such treatments. They are equally at a terminal stage, but their conditions do not interfere with respiration, nutrition, or hydration. Those patients now ask for protection of their liberty, and for the same rights as other patients are afforded.

unconstitutional but allow the legislature to consider whether it in fact desired to prohibit the conduct alleged to be protected. The legislature could seek passage of a suitably explicit measure, which could then be reviewed for constitutional sufficiency. *Quill*, 80 F.3d at 738-43 (Calabresi, J., concurring).

⁶ See Brief Amici Curiae of Bioethics Professors Supporting Respondents; Howard Brody, *Assisted Death—A Compassionate Response to a Medical Failure*, 327 New Eng. J. Med. 1384, 1385 (1992) (modern medical technology extends lives but leaves patients with an unacceptable way of dying).

I. THE CHALLENGED STATUTE INFRINGES THE LIBERTY OF COMPETENT, TERMINALLY ILL ADULTS TO MAKE END-OF-LIFE DECISIONS FREE OF UNDUE GOVERNMENT INTERFERENCE

A. A Competent, Terminally Ill Patient's End-of-Life Decision Is Within the Court's Interpretation of Liberty as Including Basic and Intimate Exercises of Personal Autonomy

This case calls upon the Court to address once again the limits of government power and the scope of individual autonomy. The Fourteenth Amendment provides that the State may not "deprive any person of life, liberty, or property, without due process of law." The scope of liberty, the "least specific and most comprehensive protection," is not clear from the face of the Constitution. *Rochin v. California*, 342 U.S. 165, 170 (1952). The Court has applied the term to many different situations. See *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting) ("[L]iberty is not a series of isolated points pricked out It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints"). In analyzing "liberty," the Court has heeded the directive of the Ninth Amendment that the rights of the people are not to be disparaged merely because every aspect could not be explicitly captured in constitutional text. See *Planned Parenthood v. Casey*, 505 U.S. 833, 847-48 (1992); *Griswold v. Connecticut*, 381 U.S. 479, 488-92 (1965) (Goldberg, J., concurring) (recognizing Ninth Amendment rule of construction that substance of liberty protected against state action by the Fourteenth Amendment is not exhausted by specific rights enumerated in the first eight amendments).

Just four years ago, in addressing one of the most persistent and difficult issues that it has ever confronted, the Court stated resoundingly:

It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter.

Casey, 505 U.S. at 847.⁷ The Court accepted that there is a core of individuality that the state is bound to respect under the Fourteenth Amendment, and the Court recognized that "[o]ur law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education." *Id.* at 851. In *Casey*, the Court reviewed its liberty jurisprudence and noted:

It is settled now, as it was when the Court heard arguments in *Roe v. Wade*, [410 U.S. 113 (1973)], that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, see *Carey v. Population Services International*, [431 U.S. 678 (1977)]; *Moore v. East Cleveland*, 431 U.S. 494 . . . (1977); *Eisenstadt v. Baird*, [405 U.S. 438 (1972)]; *Loving v. Virginia*, [388 U.S. 1 (1967)]; *Griswold v. Connecticut*, [381 U.S. 479 (1965)]; *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 . . . (1942); *Pierce v. Society of Sisters*, [268 U.S. 510 (1925)]; *Meyer v. Nebraska*, [262 U.S. 390 (1923)], as well as bodily integrity. See, e.g., *Washington v. Harper*,

⁷ The State denies the applicability of *Casey*, seeking to limit to the abortion context the principles *Casey* enunciated and characterizing its holding as compelled by stare decisis. See, e.g., Brief for the Petitioners at 31-32. *Casey*, says the State, is not worthy of stare decisis because it relied only upon stare decisis. To the contrary, *Casey* crafted a reliable, measured course for the future, and the reasoning of *Casey* applies with full force to the present case.

494 U.S. 210, 221-222 . . . (1990); *Winston v. Lee*, 470 U.S. 753 . . . (1985); *Rochin v. California*, 342 U.S. 165 . . . (1952).

505 U.S. at 849.

The holdings cited by the Court in *Casey* arise from the fact that our society has historically afforded individuals the right to make personal decisions regarding their own bodies, medical care, and, fundamentally, the future course of their lives. As Justice Powell said for the Court in one of the cases underlying *Casey*, "unless we close our eyes to the basic reasons why certain rights . . . have been accorded shelter under the Fourteenth Amendment's Due Process Clause, we cannot avoid applying the force and rationale of these precedents to the . . . choice involved in this case." *Moore v. East Cleveland*, 431 U.S. 494, 501 (1977). The liberty at issue here is another element of self-sovereignty and is of comparable importance to that involved in *Casey*.

Indeed, the Court's discussion in *Casey* as to why the Constitution protects various personal decisions applies with full force to end-of-life decisions:

These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.

505 U.S. at 851. "Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Id.* Finally, *Casey* recognizes that

the State's authority to insist that an individual endure suffering is quite limited. *Id.* at 852.

In the decision below, the Ninth Circuit correctly found that "few decisions are more personal, intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain." 79 F.3d at 813; Pet. App. A-55 to A-56. Few would deny that "no decision is more painful, delicate, personal, important, or final than the decision how and when one's life shall end." *Id.* at 837; Pet. App. A-113. The Ninth Circuit recognized that

For such patients, wracked by pain and deprived of all pleasure, a state-enforced prohibition on hastening their deaths condemns them to unrelieved misery or torture. Surely, a person's decision whether to endure or avoid such an existence constitutes one of the most, if not the most, "intimate and personal choices a person may make in a life-time," a choice that is "central to personal dignity and autonomy."

Id. at 814; Pet. App. A-57 to A-58 (quoting *Casey*, 505 U.S. at 851). Moreover, as the Ninth Circuit noted and as is discussed at greater length *infra* with respect to equal protection, the State of Washington has recognized a "fundamental right" in making end-of-life decisions, and has determined that the State's interest in preserving life is either not implicated or should ordinarily give way to the wishes of a competent, terminally ill patient. *Id.* at 817; Pet. App. A-65 to A-67.

For many patients suffering through an intolerable process of dying, "being forced to live is in fact to be forced into a particular, all-consuming, totally dependent, and indeed rigidly standardized life It is a life almost totally occupied." Jed Rubenfeld, *The Right of Privacy*, 102 Harv. L. Rev. 737, 788,

795 (1989). That is certainly true for the patient-plaintiffs. As Dr. Roe stated:

I have been almost entirely bedridden due to a combination of pain associated with the cancer in my bones and the diminishing strength in my muscles as I use them less and less. I am now unable to walk or use the commode or a bed pan without assistance. My legs are swollen with severe edema and I can scarcely use them. I have developed bed sores as a result of being bed bound. My appetite is poor and I take medications to prevent nausea and vomiting. My vision is often impaired. My left hand is weak. Drowsiness is a frequent problem. I have an indwelling urinary catheter and am sometimes incontinent of bowel.

... The pain associated with this cancer is unrelenting. It is a constant, dull pain, interspersed with sharp, severe pain provoked by movement. The site of pain moves as the disease advances. ... I take a variety of medications to manage pain. There is a tension between taking enough medication to alleviate the pain and retaining an alert mental state. It is not possible to eliminate my pain and for me to retain an alert state.

JA 23-24. Liberty certainly reaches laws that operate to "occupy" lives such as that of Dr. Roe, confining them into a painful and dependent condition.

People treat the manner of their death as of special, symbolic importance and want their deaths to confirm their own values. The moment and circumstances of death can be of profound significance. See Brief Amici Curiae of Religious

Organizations and Leaders in Support of Respondents. Control over one's final circumstances, especially because it is the last exercise of autonomy, is an intensely personal decision at a very private time. The fundamental protection from state intrusion into basic personal decisions as to the course of one's life limits the state's power to dictate this most intimate choice: the selection and implementation within the doctor-patient relationship of appropriate treatment at the end of life.

To deny a competent, dying patient the right to choose a humane, dignified death is to condemn the individual to live the final chapter of life in a state-controlled and state-approved manner. This plainly has "life long spiritual, moral and psychological" consequences both for the patient and loved ones who bear witness. See Brief for the United States as Amicus Curiae Supporting Petitioners at 14. Forcing a patient to endure a painful and dehumanizing dying process is fraught with cruelty to the patient and anguish to loved ones. See *id.* at 14 (citing *Casey*, 505 U.S. at 853). Accordingly, even the Solicitor General agrees that this is a protected liberty. Brief for the United States as Amicus Curiae Supporting Petitioners at 12-16.

Although the end-of-life decision is not explicitly discussed in the Constitution, the Court in *Casey* reaffirmed that the liberty protected by the Due Process Clause encompasses more than the rights guaranteed by the express provisions of the first eight amendments, and may well include protection of conduct that was illegal at the time the Fourteenth Amendment was ratified. 505 U.S. at 847. *Casey* decisively rejected the notion that illegality at the time the Fourteenth Amendment was ratified precludes recognition of a protected liberty. *Id.* As Justice O'Connor has noted, "due process is not a technical concept with a fixed content unrelated to time, place, and circumstances. ... The Constitution ... requires judges to examine even traditionally accepted procedures and, if necessary, to declare them invalid." Sandra D. O'Connor,

Conference on Compelling Government Interests, 55 Alb. L. Rev. 535, 542 (1992). Historical protection is a sufficient but not a necessary condition to recognition of an additional aspect of liberty.

Thus, the Second Circuit's reluctance in *Quill v. Vacco* to recognize the dying patient's liberty was based on the mistaken understanding that *Bowers v. Hardwick*, 478 U.S. 186 (1986), directs lower courts to refrain from recognizing new aspects of liberty, even where this Court's analytical standards have been met. 80 F.3d at 725.⁸ This Court has long accepted its duty to apply the concept of liberty to appropriate situations that it had not previously been called upon to address, just as a "prime part of the history of our Constitution . . . is the story of the extension of constitutional rights and protections to people once ignored or excluded." *United States v. Virginia*, 116 S. Ct. 2264, 2287 (U.S. 1996).

The State argues that the cases recognizing various aspects of liberty are distinguishable because they involve activities allowing the individual "a broader participation in life and

⁸ The Second Circuit's deferral to this Court betrayed no disagreement with respondents that the fundamental personal decision at stake here is within the core of protected individual liberty:

[W]hat business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's "right to define her own concept of existence, of meaning, of the universe, and of the mystery of human life" . . . when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answer to these questions: "None."

80 F.3d at 730 (quoting *Casey*, 505 U.S. at 851).

society" or, conversely, because they are limited to a right to be free of bodily invasion. Brief for the Petitioners at 26-27. This contention is unpersuasive. Those cases consistently protect decisions arising at key points in one's life, decisions that help define and shape that life. Few of the cases, and certainly not the abortion decisions, involve direct bodily intrusion. The decision how to die is the final life-shaping decision a person can make, and is as important, personal, and private as other decisions the Constitution protects from state domination. The circumstances certainly narrow a dying patient's participation in life and society, but the right at issue here broadens the patient's control over what is left of such participation. Any element of control during those last days is precious. Many of the Court's liberty decisions have not involved a person's desire to enjoy broader participation; in fact, some have involved the individual's right to choose among quite unpleasant alternatives. *E.g.*, *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990); *Washington v. Harper*, 494 U.S. 210 (1990); *Rochin v. California*, 342 U.S. 165 (1952).

Several of the State's amici devote their briefs to the history of proscriptions against suicide. The Court in *Casey* decisively rejected any general rule that liberty is limited to historically and traditionally protected rights. 505 U.S. at 847-50; *see Rochin*, 342 U.S. at 171 (rights cannot be frozen "at some fixed stage of time or thought"); *Roe*, 410 U.S. at 118 (most states had abortion prohibitions similar to that of Texas). More specifically, in *Cruzan* the Court effectively rejected Justice Scalia's contention that state laws prohibiting suicide precluded the recognition of a right to hasten death by directing the removal of life support. The proper question is whether society, and the Court's constitutional interpretation, has afforded individuals the right to make personal decisions

regarding their bodies, medical care, and life-course without burdensome government intrusion.⁹ The answer is plainly yes.

Further, history reflects a growing trend in favor of the terminally ill patient's control of end-of-life decision-making. See *Compassion*, 79 F.3d at 821-22; Pet. App. A-75 to A-77. Indeed, many of the state court decisions dealing with the patient's right to hasten death by deciding to terminate medical care have recognized that right as not self-contained but as one aspect of the common law protection of self-determination and personal autonomy. E.g., *In re Gardner*, 534 A.2d 947, 950 (Me. 1987); *In re Conroy*, 486 A.2d 1209, 1221-23 (N.J. 1985). The Washington Supreme Court held that such principles were fundamental to the common law and to the state (and federal) constitution. *In re Welfare of Colyer*, 99 Wash. 2d 114, 660 P.2d 738, 741-42 (1983); *In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372, 1376 (1984); *In re Guardianship of Grant*, 109 Wash. 2d 545, 747 P.2d 445, 449 (1987).

It is true that, for many people in our society, a competent, terminally ill person's liberty to shape death in this manner raises religious implications, just as does abortion.¹⁰ Religious

⁹ Even if the historical inquiry focuses on the act of suicide or assisted suicide, the Ninth Circuit is correct that the historical record is checkered. 79 F.3d at 806-10; Pet. App. A-39 to A-47; see Maria T. CeloCruz, *Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?*, 18 Am. J.L. & Med. 369, 373-75 (1992).

¹⁰ See, e.g., Brief Amici Curiae of Metropolitan Catholic Physicians Guild in Support of Petitioners at 14-23; Brief Amicus Curiae of Evangelical Lutheran Church in America in Support of Petitioners at 1-3, 22-24; Brief Amici Curiae of Catholic Health Association in Support of Petitioners at 16-18. See generally Matthew P. Previn, *Assisted Suicide*

objections to the exercise of individual liberty, however, are reason to leave such issues to individual conscience, not the state. See Brief Amicus Curiae of Religious Organizations and Leaders in Support of Respondents. As recognized by the Court in *Casey*, religious concerns about a liberty

cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code. The underlying constitutional issue is whether the State can resolve these philosophic questions in such a definitive way that a [person] lacks all choice in the matter

....

505 U.S. at 850; see *Poe v. Ullman*, 367 U.S. at 545 (Harlan, J., dissenting) ("the mere assertion that the action of the State finds justification in the controversial realm of morals cannot justify alone any and every restriction it imposes").

Here, the question is whether the State can resolve the philosophical questions relating to the end of life so definitively that competent, terminally ill adults lack any choice in the matter. The answer, consistent with the Fourteenth Amendment, must be no. To hold otherwise would necessarily mean that the State's religious or philosophical preference outweighs that of the competent, dying patient. By compelling individuals to endure suffering at the end of their lives, the state devalues the nobility of the free will and faith that many would otherwise show in willingly accepting the circumstances of death, no matter how painful and humiliating.

The State attempts to distinguish the decision to seek assistance in dying from the decision to have an abortion on the grounds that "the decision whether to have a child . . . is

something over which humans can exercise a great deal of personal autonomy." Brief for the Petitioners at 28. This is circular and inconsistent. Absent the State's interference, a terminally ill patient could exercise the full measure of autonomy that the circumstances allow over how and when to die, and such autonomy is today legal with respect to the decision to accept, forgo, or withdraw life-sustaining treatment.

Similarly flawed is the Solicitor General's attempt to distinguish the abortion cases on the grounds that the decision to abort implicates a "combination" or "constellation" of interests. Brief for the United States as Amicus Curiae Supporting Petitioners at 15.¹¹ The United States recognizes that both abortion and the present case implicate a desire to avoid pain and suffering, but argues that the abortion equation involves much more than that. Avoidance of suffering, while undoubtedly significant here, is still but one part of a terminally ill patient's decision to die in a humane and dignified manner. The equation here includes the freedoms to exercise conscience and personal autonomy, to avoid irreversible bodily disintegration, to choose the course of one's life, and to subscribe to a philosophy about the end of life that is different from that of the 19th century Washington legislature that enacted the statute now at issue.

The American Medical Association asserts that pain management can ease one form of suffering, physical pain, and

¹¹ The Solicitor General's argument that abortion precedent is premised on principles of gender equality is inaccurate. While the Court recognized an equality component in liberty, which is also important here, the Court has always found the right of reproductive choice to be protected as a matter of human liberty, and not just as a matter of gender equality. *E.g.* *Casey*, 505 U.S. at 851, 853; *Carey*, 431 U.S. at 684-86; *Roe*, 410 U.S. at 152-53; *Eisenstadt*, 405 U.S. at 453; *Griswold*, 381 U.S. at 485-86.

reduce many patients' desire for a hastened death. Brief Amicus Curiae of American Medical Association in Support of Petitioners at 10. The State can act to assure that inadequately treated pain does not motivate the choice of a hastened death. Successful pain management, however, would at most mitigate for some patients the need to exercise the liberty in question. Even where pain management is successful, *Casey* and *Cruzan* make clear that liberty is not limited to the avoidance of pain, especially when avoidance is accomplished with medication that reduces control over mind and body, thus imposing on the patient even more incapacity and increasing the suffering from feelings of degradation and helplessness. Moreover, the undisputed factual record of this case is that medical science cannot sufficiently ease the physical pain of the patient-plaintiffs and many others. JA 34-35, 49, 73. *See also* Brief of Coalition of Hospice Professionals as Amicus Curiae for Affirmance of the Judgments Below.

The AMA concedes this and suggests that, where pain cannot be alleviated, the doctor can sedate the patient "to a sleep-like state" until she dies of starvation or dehydration "days or weeks" later. Brief Amicus Curiae of American Medical Association in Support of Petitioners at 6.¹² This "terminal sedation" option — voluntarily submitting to a drug-induced coma while one's body disintegrates and loved ones stand vigil — is monstrous to many patients. Moreover, a patient sedated in this manner might only *appear* to be insensate. Even patients under general anesthesia — a deeper

¹² *See* Robert D. Truog et al., *Barbiturates in the Care of the Terminally Ill*, 327 New Eng. J. Med. 1678 (1992); Nathan Chernoy et al., *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. of Palliative Care 31-38 (1994) (describing practice of terminal sedation).

state of sedation — often feel and hear.¹³ Hence, terminal sedation may serve only to make the death less excruciating to observers. Certainly, allowing physicians to administer coma-inducing medications and to monitor patients in that state until dehydration or starvation eventually causes death cannot be reconciled with the AMA's ethical concerns and the action/omission distinction suggested by a number of the State's amici.

The Ninth Circuit is correct that the aspect of liberty invoked here follows naturally from this Court's prior decisions. 79 F.3d at 813-14; Pet. App. A-56 to A-58. Moreover, reposing end-of-life decisions with the dying patient is essential to ensure that the government not be empowered either to deny the option of a hastened death or to compel one. See Brief of Respondents in No. 95-1858. If the power to determine whether to continue a pregnancy rested with the state, for example, the state could compel abortion as well as deny it. So, too, if the power to decide how a life should end is vested in the state, the state might determine that, since death is inevitable, no purpose is served by honoring a futile choice to suffer through a few more days of life.

B. The Liberty to Direct the Withdrawal of Medical Treatment to Hasten Death Is No Different Than That in Choosing to Hasten Impending Death With Medications Prescribed For That Purpose

Of all the Court's decisions with respect to personal liberty, perhaps the closest to the present case factually is *Cru-*

¹³ See generally R. Cork et al., *Is There Implicit Memory After Propofol Sedation?*, 76 Brit. J. Anaesthesia 492 (1996); N. Moerman et al., *Awareness and Recall During General Anesthesia*, 79 Anesthesiology 454 (1993).

zan. There the Court acknowledged that competent, dying persons have the right to direct the removal of life-sustaining medical treatment and thus hasten death. 497 U.S. at 278; see Brief for the United States as Amicus Curiae Supporting Petitioners at 13-14. The Court recognized that the liberty to make this end-of-life decision is uniquely and "deeply personal." 497 U.S. at 281; see *id.* at 289 (O'Connor, J., concurring). The Court in *Cruzan* addressed the question of the level of evidence Missouri could require as to the wishes of a presently incompetent person that life-sustaining treatment be withdrawn. The Court made it clear that a state's interest in this area is limited to ensuring a voluntary decision — in safeguarding personal autonomy but not in interfering with it. *Id.* at 281.

The dissenting opinions differed as to the limitations that the State could impose to ensure voluntariness, but agreed with the majority as to the personal nature of end-of-life decisions and the limited state interest in such decisions:

Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence.

Id. at 310-12 (Brennan, J., with Marshall & Blackmun, JJ., dissenting).

Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly "so rooted in the traditions and conscience of our people as to be ranked as fundamental." . . .

The more precise constitutional significance of death is difficult to describe; not much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience.

Id. at 343 (Stevens, J., dissenting) (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

Dr. Roe, Mr. Doe, and Mr. Poe were indisputably competent, and their requests were indisputably voluntary. Respondents do not challenge procedures such as those in *Cruzan* that seek to assure rather than deny free will. The Court's acknowledgment in *Cruzan* of the profoundly personal and protected nature of the decision to die through refusal of medical treatment squarely supports recognizing that aspect of liberty claimed here. *See Compassion*, 79 F.3d at 824; Pet. App. A-82. The Solicitor General agrees. *See* Brief for the United States as Amicus Curiae Supporting Petitioners at 13-14.

The patient's decision in *Cruzan* had not been made contemporaneously with the circumstances that triggered the potential effectuation of the decision, and it had not been memorialized in any manner, giving rise to significant questions regarding the patient's true wishes with regard to maintenance of life support. Whatever had been the case at one time, there was no way to determine if it was still Nancy Cruzan's wish to die. Because of her comatose condition, she would not have known if her wishes had been ignored. In contrast, the patient-plaintiffs here were available to have their competence and voluntariness tested, were capable of retracting their decisions, and had made their decisions clear. Nonetheless, the State required Dr. Roe, Mr. Doe, and Mr. Poe to continue to suffer excruciating pain, anxiety, and loss of

dignity and to know that those who cared for them were compelled to reject their requests for help or face prosecution.

From the patient's perspective, the decision to direct the withdrawal of a feeding tube or a respirator, or to submit to terminal sedation, is no different than the decision to choose to hasten death by consuming drugs prescribed for this purpose. In each situation, patients request such assistance for the same reason: they want to exercise what control they can over when and how they die. In each situation, plaintiffs make the decisions based upon their own values, in consultation with their own doctor and, if they wish, their own families.

Similarly, from the doctor's perspective, honoring the patient's decision to direct the withdrawal of treatment or to submit to terminal sedation is assisting in a patient's wish to die. The recognized right to direct the withdrawal of treatment requires medical assistance in, for example, removing a feeding tube or ventilator and in administering medications to ease pain, the sensation of suffocation, and anxiety while that is done. Such assistance requires far more physician action than the assistance sought in this case, as acknowledged by the Solicitor General. Brief for the United States as Amicus Curiae Supporting Petitioners in No. 95-1858 at 12. The provision of terminal sedation requires affirmative and continuing medical assistance in initiating the coma through the administration of medication and maintaining it until starvation or dehydration causes death.¹⁴ Paul Rousseau, *Terminal*

¹⁴ Some of the State's amici assert that the kind of physician assistance sought by the patient-plaintiffs would be unethical. Such beliefs did not deter the Court from recognizing a constitutionally protected right in *Roe v. Wade*. And they did not halt recognition of the right to direct the withdrawal of life support. *Colyer*, 660 P.2d at 744 ("It is not necessary to deny a right of self-determination to a patient in order to recognize the interests of doctors, hospitals, and medical personnel in attendance on

Sedation in the Care of Dying Patients, 156 Archives of Internal Med. 1785 (1996).

Thus, the constitutional principle behind recognizing the patient's liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice to hasten impending death by consuming lethal medication. The District Court and the Ninth Circuit in this case, as well as the Second Circuit in *Quill*, found that no relevant distinction could be drawn between the decision to direct the withdrawal of life-sustaining medical treatment and the decision of a mentally competent, terminally ill adult to consume medications prescribed for the purpose of hastening death. *Compassion*, 79 F.3d at 821-24; Pet. App. A-75 to A-82; 850 F. Supp. at 1467; Pet. App. E-27 to E-28; *Quill*, 80 F.3d at 727. From the patient's or the doctor's perspective, it is exactly the same choice, and the record here establishes that medical assistance in hastening death is necessary to permit implementation of that choice for persons not on life support. JA 35, 49, 55-56, 73, 190.

the patient."). Moreover, where studies have been conducted, a majority of physicians already view physician assistance in the case of mentally competent, terminally ill patients as ethical. See, e.g., Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 New Eng. J. Med. 89 (1994); Melinda A. Lee, *Legalizing Assisted Suicide — Views of Physicians in Oregon*, 334 New Eng. J. Med. 310 (1996). Legalizing the practice, bringing it into the open, and imposing protection for the patient can only increase the integrity of the practice and of the profession. See, e.g., Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119, 120 (1994); Brief Amici Curiae of Bioethics Professors Supporting Respondents; Brief Amicus Curiae of American College of Legal Medicine. Physicians who do not wish to honor a patient's request can refer the patient to another doctor. See *Smith v. Cote*, 513 A.2d 341, 355 (N.H. 1986) (Souter, J., concurring); Wash. Rev. Code § 70.122.060(4).

The alternatives to physician assistance involve violent means — almost unimaginable for a competent person and leaving a horrible last impression on family members — or an uncertain and often botched attempt with poison or drugs not prescribed for this purpose.¹⁵ Dr. Glucksberg's patient was forced to jump from a bridge; Dr. Halperin's to suffocate herself. The undisputed record shows that terminally ill persons who seek to hasten death need medical counseling regarding the type of drugs and the amount and manner in which they should be taken, as well as a prescription, which only a doctor can provide.¹⁶ See JA 190. Attempts to hasten death without such advice frequently fail, often leaving the patient in worse shape than before, or succeed only after terrible pain and suffering.¹⁷ *Id.*

¹⁵ The violent death by self-inflicted gunshot of Nobel Physics Laureate Percy Bridgman, in the final stages of cancer, exemplifies the brutality of this option. Professor Bridgman's last message: "It is not decent for Society to make a man do this to himself. Probably, this is the last day I will be able to do it myself." Sherwin B. Nuland, *How We Die: Reflections on Life's Final Chapter* 152-53 (1993); see Brief Amici Curiae of Surviving Family Members in Support of Respondents.

¹⁶ Patients often choose not to use such a prescription. See Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 922 (1996). Knowing that they control how much suffering they must endure reduces the patients' anxiety and helps avoid premature violent deaths such as that of Professor Bridgman.

¹⁷ See Russel D. Ogden, *Euthanasia, Assisted Suicide & AIDS* (1994); JA 190 (emotional and psychological effect of inability to obtain assistance can be devastating to terminal patients who feel abandoned by their physicians when most in need of their help); Brief Amici Curiae of Surviving Family Members in Support of Respondents; Clyde H. Farnsworth, *Bungled AIDS Suicides Often Increase the Suffering*, N.Y. Times, June 14, 1994, at B9.

C. The Challenged Statute Does Not Serve Legitimate State Interests; State Regulation Would Better Protect Any Such Interests

The liberty here is as substantial and fundamental as that recognized in *Casey*, *Cruzan*, and Wash. Rev. Code § 70.122.010. As discussed in the Brief of Respondents in No. 95-1858, however, the Court need not categorize this aspect of liberty, or determine which system of categorization, if any, is appropriate. The prohibition must fail under the venerable strict scrutiny standard, the undue burden model employed in *Casey*, or the rational relationship test. The statute simply does not serve the interests asserted by the State of Washington. See Brief Amici Curiae of Law Professors in Support of Respondents.

The three interests identified by the State are: (1) protecting terminally ill patients against being extinguished by third parties against their will because their lives are viewed as having little quality; (2) protecting patients against physician errors in judgment as to mental competence and terminal illness; and (3) protecting the State's right to choose whether or not to legalize this practice. Brief for the Petitioners at 33-36, 47-49. As discussed in detail below, none of these interests is sufficient to justify the total prohibition of individual liberty in these circumstances, and none is served by this statute.

The challenged statute absolutely forbids physician assistance, even where, as here, the patient's voluntariness of choice, mental competence, and terminal state are undisputed. The statute is not an effort to discourage, to inform, or to regulate. See *Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 446-47 (1983) (state may require provision of accurate medical information to abortion patient); *Maher v. Roe*, 432 U.S. 464, 474 (1977) (state may express preference against abortion); *Roe*, 410 U.S. at 150 (state may regulate to

ensure safety of abortion). Wash. Rev. Code § 9A.36.060 is a flat prohibition, and it does not serve the supposed ends argued by the State. "[L]iberty may not be interfered with, under the guise of protecting the public interest, by legislative action which is arbitrary or without reasonable relation to some purpose within the competency of the state to effect." *Meyer v. Nebraska*, 262 U.S. 390, 399-400 (1923).¹⁸

Indeed, when one compares the statute to the asserted state purposes, it is clear that there is so little "fit" that either the statute is irrational or it serves some other, unstated and undefended purpose. See *Romer v. Evans*, 134 L. Ed. 2d 855, 865-66, 868 (1996). The statute is grossly overinclusive; it interferes with the liberty of even those who are clearly competent and uncoerced. It is equally underinclusive; it does not prohibit the same decision, with the same fatal consequences, for those on life support or those who would submit to a medically induced coma and starvation.¹⁹ The statute allows

¹⁸ Some amici refer to adverse implications for survivors. The Washington Supreme Court has held that this interest does not exist unless family members object to the patient's action. *Colyer*, 660 P.2d at 743. Moreover, the act of a mentally competent, terminally ill adult to hasten impending death is nothing like the typical suicide, as shown by the State's legalization of assisted death through withdrawal of life support. Indeed, it is undisputed on the record that by recognizing the choice to hasten death with drugs prescribed for that purpose, death will be nonviolent and humane, easing a tortured dying process. The inevitable mourning can proceed with the comfort of knowing a loved one's wishes regarding this most personal and profound matter were respected and that the patient suffered less. See JA 74-75; *Compassion*, 79 F.3d at 827; Pet. App. A-90; Brief Amici Curiae of Surviving Family Members in Support of Respondents.

¹⁹ The State has done little to protect against abuse in the context of withdrawal of life support. E.g., Wash. Rev. Code § 70.122.020(8) and .030(2) (no second opinion required as to terminal condition). Reason-

withdrawal of life support even though patients on life support, due to its extended cost, are more likely to be pressured to hasten death. The statute does not serve the mentally ill or weak-willed as effectively as would tailored regulation. The current prohibition leaves those individuals vulnerable to the unrestrained "back alley" practitioner, rather than careful, open, peer-reviewed opinions by doctors currently unwilling to risk a crime prosecution. The legitimate purposes that the State advances in support of the law can be accomplished through regulation that would not unduly burden liberty, and the State must legislate within that framework.

This case involves state interests of less weight than those at stake in *Casey*. In upholding the right of women to choose, the Court in *Casey* recognized that abortion is an "act fraught with consequences for others" and raises numerous potentially conflicting interests, particularly that of the separate, silent life of the fetus. 505 U.S. at 871. It is the state interest in fetal life that makes the abortion cases so difficult. This case directly involves no life apart from that of the individual making the personal choice.

1. The Challenged Statute Is Not Necessary to Protect Against Third-Party Usurpation of the Patient's Control Over the Remaining Days of Life

The State of Washington has no interest in mandating that the lives of the terminally ill be extended as long as possible. Indeed, the State disavows any such interest in recognizing a terminally ill patient's right to direct withdrawal of life support. Wash. Rev. Code § 70.122.051. Thus, as the Ninth Circuit noted, the State has accepted the notion that its inter-

est in preserving life should ordinarily give way, in the case of a competent, terminally ill adult, to the wishes of the patient. 79 F.3d at 817; Pet. App. A-65. The existing exception to the challenged statute acknowledges that denial of assistance in dying extinguishes the only liberty a terminally ill person has left. *Id.* at 820; Pet. App. A-72; see *Quill*, 80 F.3d at 729. For a patient at death's door, the choice is not between continuing life and bringing on death but between a painful and degrading death or a humane and dignified one.

As was noted in a case accepted by the Washington Supreme Court with respect to the interests of the State in the lives of the terminally ill: "[T]he individual's right to privacy grows as . . . the prognosis dims." *In re Quinlan*, 355 A.2d 647, 664 (N.J.), cert. denied, 429 U.S. 922 (1976), discussed in *Colyer*, 660 P.2d at 743.

Recognition of a dying patient's liberty to choose how to die would in no way suggest that physicians may kill those patients who do not request assistance in dying. The State has a strong interest in protecting against usurpation of the dying patient's wishes by others. To say that the State must respect the individual's autonomy does not imply that the State must stand by should others try to override that autonomy and extinguish that life. The legalization of a patient's right to direct withdrawal of life support did not increase the risk of such patients to involuntary euthanasia or other forms of murder, much less legalize such conduct. The State retains an undiminished interest in ensuring that the lives of such patients, however short, are protected against extinction against their will by third parties. The value of life is cheapened not by allowing a humane death but by denying a competent human being the right of choice.

2. Ensuring That Assistance Is Provided Only to Mentally Competent, Uncoerced, Terminally Ill Patients Better Protects the State's Interests Than Does the Current Covert Practice

(a) Prohibiting All Competent, Uncoerced, Terminally Ill Patients From Exercising a Right to Protect a Few Incompetent or Coerced Patients From Erroneously Exercising That Right Does Not Serve Any State Interest

The State's interest in preventing suicide by those with mental illness or susceptible to "undue influence" is premised on assuring free choice. As with refusal of life-sustaining treatment, an interest in free choice is not furthered by denying choice to those who are mentally competent and exercising free will.²⁰ "If the state's interest in preventing suicide is really an interest in preventing irrational suicides, coerced suicides, or suicides by the young, then the state has little interest, if any, in preventing informed, competent, terminally ill individuals who are free from undue influence from committing suicide." Mark Strasser, *Assisted Suicide and the Competent Terminally Ill*, 74 Or. L. Rev. 539, 558 (1995); see *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977) (state's interest in the

²⁰ Various of the State's amici contend that no dying patient desiring to hasten death could be free of mental illness. This factual contention contradicts the undisputed record of this case. JA 22-31. Even the New York State Task Force ("Report"), relied upon heavily by petitioners and amici, refutes this "myth." Report at 16. The Task Force reports that depression is the exception in the terminally ill and can be diagnosed. *Id.* at 13, 26; see Brief Amici Curiae of Mental Health Professionals in Support of Respondents.

prevention of irrational self-destruction is not at issue in competent, rational decision to refuse medical treatment when death is impending) (cited with approval on this point by the Washington Supreme Court in *Colyer*, 660 P.2d at 743).

The patient-plaintiffs did not suffer from mental illness and were acting of their own free will. JA 25, 28, 31. It is uncontested that the patients whose claims are asserted through the physician-plaintiffs are mentally competent, and that physicians can determine who is competent. JA 35, 49, 55, 73; *Compassion*, 850 F. Supp. at 1458; Pet. App. E-8. The present case is limited to those who seek a humane, hastened death not because they are troubled, disturbed, misled, confused, unduly influenced, or in need of psychiatric care, but rather because they are dying and suffering unbearably in the process. The Ninth Circuit recognized that the liberty extends only to such patients. 79 F.3d at 793, 834, 837; Pet. App. A-9 to A-10, A-106, A-113 to A-114. This Court drew the same dividing line in *Cruzan*. 497 U.S. at 279. The State remains free to protect those not facing death and to enact procedures to protect those who are terminally ill to ensure that their end-of-life decision is informed and voluntary. The State certainly remains free to prosecute those who "knowingly cause . . . another person to attempt suicide."

The State of Washington has previously convinced this Court that doctors can determine if someone is suffering from a mental disorder and that review by two doctors is adequate to assure accuracy. *Washington v. Harper*, 494 U.S. at 222, 232 (1990). In that case, the Court also agreed with the State that it would not assume that doctors would abuse their power. *Id.* at 222 & n.8. Moreover, the right claimed in the present case is access to life-ending medication that the patient may self-administer if the patient so chooses, providing an additional assurance of volition.

The State and some of its amici contend that it would not be permissible to limit the right at issue to the mentally competent. This Court accepted that boundary without question in *Cruzan*, 497 U.S. at 277-79, 287 n.2. The right at issue is by definition a very personal one that involves a conscious decision by the individual. A right of self-determination would never justify, and is in fact antithetical to, involuntary euthanasia. The State's interest in protecting incompetent individuals is undisputed and of great weight. The state protects the incompetent in matters ranging from contracts to criminal trials; there has been no "slippery slope" from allowing competent citizens to exercise those rights to allowing incompetent citizens to do so. *E.g.*, *Faretta v. California*, 422 U.S. 806, 833-35 (1975) ("the inestimable worth of free choice" belongs to competent citizens exercising "informed free will").

Finally, some of the State's amici urge that shortcomings in the health care system are so coercive as to justify a prohibition on choice. This supposed state interest has never been espoused by the State and would justify the governmental prohibition of any patient choice that might be influenced by limited finances and care options. Free will under our Constitution is not limited only to easy decisions in uncomplicated circumstances. The solution to this concern is to fix the risks in the health care system, not to trample individual liberty. *See, e.g.*, Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204 (prohibiting premature discharge from hospital after childbirth).

(b) Terminal Illness Is a Workable Boundary

The State suggests, and some of the State's amici contend, that it is difficult in some cases to determine when a patient has reached the terminal phase. Of course, no one knew for sure that Nancy Cruzan would not have regained conscious-

ness. *See* 497 U.S. at 266-67 ("virtually no chance"). In fact, since 1979 Washington has used the terminal dividing line for this purpose with respect to life support and does not even require a second opinion, Wash. Rev. Code § 70.122.020(8)-(9), and most other states and the federal government define and use "terminal" for a variety of state functions, including authority to direct the withdrawal of life support.²¹ This Court need not define terminal as an initial matter; that can be left to the states. The important point is that terminal can be defined. Whatever might have been the case in 1854, the record of this case shows that, for many patients, physicians now can determine terminal stage with assurance.²² The State did not dispute the record below that the physician-plaintiffs and other doctors can determine when many illnesses have progressed to this stage.²³

²¹ *E.g.*, Cal. Health & Safety Code § 7186(j); 42 U.S.C. 1395x(dd)(3)(A).

²² The medical profession also utilizes the terminal diagnosis as a clinical bright line in provision of terminal sedation. *See* Paul Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Archives of Internal Med. 1785, 1785 (1996) ("prior to initiation of sedation, clinicians must ascertain the need for sedating therapy, including the presence of a terminal disease with impending death").

²³ There is no right for those patients who are not terminally ill and not imminently facing death. The State has a real interest in preserving the lives of those who can still contribute to society and have the potential to enjoy life again. As explained in the Brief of Respondents in No. 95-1858, the right of patients to direct the withdrawal of life support with the intent to bring about their own deaths is limited to the terminally ill or those in a permanent vegetative state. In Washington, both statutory and common law are so limited. Other states have created exceptions for patients who refuse treatment for religious reasons. If, as some of the State's amici argue, there are states that, regardless of religious considerations, allow refusal of temporary life support for conscious patients who are not terminally ill, but simply wish to die, that

The claimed state interest can support an absolute prohibition as to all patients only if the rights of those where accurate diagnosis is possible must be sacrificed to avoid any risk of physician error.²⁴ As discussed in the Brief of Respondents in No. 95-1858, this sort of sacrifice has never been permitted under our Constitution. As with all human endeavors, diagnosis of terminal illness is not infallible, but that does not justify a total prohibition on the right to choose a humane, hastened death. As the Court noted in *Casey*, in dealing with the question of fetal viability:

[T]here is no line other than viability which is more workable. To be sure, as we have said, there may be some medical developments that affect the precise point of viability, . . . but this is an imprecision within tolerable limits given that the medical community and all those who must apply its discoveries will continue to explore the matter.

505 U.S. at 870.

is not a right guaranteed by the Constitution and is instead one created, wisely or unwisely, by such states. Protecting the constitutional right at stake here will not alter the wisdom of those states. Contrary to the assertions of the State's amici, there has been no slide down the slippery slope in the Netherlands, where the practice of assistance in dying, though still illegal, is conducted more openly. See *Special Reports from the Netherlands*, 335 New Eng. J. Med. 1676, 1699, 1706 (1996); *Quill*, 80 F.3d at 730-31; *Compassion*, 79 F.3d at 830 n.114; Brief Amici Curiae of Bioethics Professors Supporting Respondents.

²⁴ If error occurs, it is generally in the direction of excessive optimism regarding remaining life expectancy. See, e.g., Lorna E. Forster & Joanne Lynn, *Predicting Life-Span for Applicants to Inpatient Hospice*, 148 Archives of Internal Med. 2540 (1988); David B. Reuben et al., *Clinical Symptoms and Length of Survival in Patients With Terminal Cancer*, 148 Archives of Internal Med. 1586 (1988).

The line drawn by the Ninth Circuit is reasoned and workable and serves the rule that "[l]iberty must not be extinguished for want of a line that is clear." *Id.* at 869. "Constitutional rights do not always have easily ascertainable boundaries." *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 771 (1986). Certainly the doctor should inform the patient of the risks of misdiagnosis, but that does not justify prohibiting informed patient choice.

The primary concern of the State's amici appears to be that the possibility of an erroneous diagnosis means that no line separates the terminally ill from others, so that the "slippery slope" toward assisted suicide on demand will be unavoidable. To the contrary, erroneous placement of a person on the wrong side of a bright line does not mean that the line does not exist, nor does it constitute an endorsement of suicide on demand by the healthy. If such an error were to occur, it would be because a mentally competent person, based upon medical advice (after whatever reasonable safeguards regarding such advice the State wished to impose), made the voluntary choice to end suffering. An error of this sort would not open the door to euthanasia.

If rights could be denied for fear that they might be exercised unwisely or upon inaccurate information, they would not be rights at all. Numerous rights can be exercised upon inaccurate information: marrying, voting, having an abortion, and even refusing medical treatment. "[I]t is far better to permit some individuals to make incorrect decisions than to deny all individuals the right to make decisions that have a profound effect upon their destiny." *Id.* at 781-82 (Stevens, J., concurring).

Finally, some of the State's amici contend that the Ninth Circuit has stripped elderly, chronically ill, or disabled persons of the State's protection. Nothing in the Ninth Circuit's deci-

sion supports this. All such persons are fully entitled to protection against coercion and other abuse, and all are, if competent, as entitled to a humane death as anyone else when they reach the final stages of dying. See Brief Amici Curiae of GMHC, LAMBDA, and Prominent Americans with Disabilities in Support of Respondents.

(c) The Random, Covert, and Unregulated Practice Under the Existing Prohibition Poses Greater Risk to the State's Interests

Entirely absent from the State's brief is any mention of the well-established fact that, notwithstanding the criminal prohibition, physicians frequently provide assistance in dying to patients.²⁵ This reflects the demand of such patients for their liberty, and the respect of many doctors for its exercise. This assistance currently is provided in a covert manner without oversight. No safeguards ensure that the patient's decision is informed and voluntary. No other professionals are involved to ensure that the patient is indeed in the terminal phase of illness, is mentally competent, and has had the benefit of

²⁵ See, e.g., Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919 (1996) (in year preceding study, 12 percent of physicians had been asked to provide assistance in hastening death, and 24 percent of patients making such requests received assistance); Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119, 120 (1994) ("relatively widespread secret practice of physician-assisted death in the United States, which is completely unregulated"); Richard A. Knox, *1 in 5 Doctors Say They Assisted a Patient's Death, Survey Finds*, Boston Globe, Feb. 28, 1992, at 5; Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients, A Second Look*, 320 New Eng. J. Med. 844 (1989); Sherwin B. Nuland, *How We Die: Reflections on Life's Final Chapter* 153 (1993) ("a muted practice that has existed since Aesculapius was in swaddling clothes").

palliative care. Only affluent and educated consumers of medical services are likely to have access to a willing, competent physician, in much the same way as those with financial and educational means could obtain abortions prior to *Roe*.²⁶ Patients without access to a willing, competent provider must abandon their rights or seek a "back alley" provider who may be a careless, unqualified charlatan.²⁷ The State cannot reconcile this situation with its asserted interest.

3. Federalism Does Not Justify Unlimited Government Power at the Expense of Individual Autonomy

The State's argument before the Court is almost entirely premised upon federalism — contending that state governments, rather than competent, dying citizens, are empowered under the Constitution to decide how such citizens should die.

²⁶ Because clandestine assistance is available to the powerful, the notion that the political process can be expected to protect all citizens in this context, Brief for the United States as Amicus Curiae Supporting Petitioners at 11-12, is as factually flawed as it is legally irrelevant. Moreover, our culture is one of denial where mortality is concerned. Death is generally taboo. Kathy Charmaz, *The Social Reality of Death* 67, 83-87 (1980); William E. Phipps, *Death: Confronting the Reality* 55-56 (1987); Philippe Aries, *The Hour of Our Death* 569-571 (1981); Louise Harmon, *Fragments on the Deathwatch*, 77 Minn. L. Rev. 1, 105-18 (1992). Citizens do not deal with mortality until directly confronted with imminent death. See Ernest Becker, *The Denial of Death* (1973). The constituency that would bring about political change is composed of ailing, dying persons who cannot direct their waning energy to political action.

²⁷ See Mark Strasser, *Assisted Suicide and the Competent Terminally Ill*, 74 Or. L. Rev. 539, 604 (1995) ("it may be that individuals like Kevorkian are able to break laws precisely because of society's failure to offer legal procedures by which people can achieve a painless, dignified death") (footnote omitted).

This argument is contradicted by the Fourteenth Amendment's explicit restructuring of federalism, by the Ninth Amendment's rule for interpreting the Fourteenth Amendment, and by the Court's decisions interpreting both.

The State argues primarily that the decision is "a complex and controversial issue" that should be left to state legislatures.²⁸ *E.g.*, Brief for the Petitioners at 9. The State contends not so much that exercise of this right would compromise its substantive interests, but that recognizing the citizen's right to choose would deny the State's right to choose.

Constitutional liberty belongs to individuals, not states, however, and the question of whether liberty must give way to supposed state objectives cannot be left totally to the states. "[T]his Court too has its responsibility." *Rochin v. California*, 342 U.S. at 168-69. Thus, the State's citation to *Casey* for the proposition that "it is conventional constitutional doctrine that where reasonable people can disagree the government can adopt one position or the other," Brief for the Petitioners at 38, does not advance its position. The very next sentence in *Casey* recognizes that "[t]hat theorem, however, assumes a state of affairs in which the choice does not intrude upon a protected liberty." 505 U.S. at 851; *see* Brief Amici Curiae of State Legislators in Support of Respondents.

²⁸ The State's invocation of Justice Brandeis's laboratory of social policy experimentation is misplaced. *See* Brief for the Petitioners at 48. The ruling below invites "dialogue with legislators" and leaves appropriate room for the political process to operate. Ruth B. Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. Rev. 1185, 1204-05 (1992). Striking down the flat prohibition of the exercise of liberty of mentally competent, terminally ill patients leaves the states free to regulate exercise of that liberty.

Moreover, the State must assert more than an abstract religious or philosophical disagreement; the statute must serve a legitimate public purpose. It would directly contradict the most basic, anti-authoritarian premise of the constitutional guarantee of liberty to permit specific exercises of rights to be subordinated to the controversial, moral dictates of a majority or powerful minority. Indeed, it has long been recognized that, where the democratic process impinges on constitutional rights, "the judiciary then has a duty to intervene in the democratic process." *Schweiker v. Wilson*, 450 U.S. 221, 230 (1981). The Constitution protects citizens against moral and political domination by the state, especially with regard to freedoms of conscience and control over one's destiny. *See Wooley v. Maynard*, 430 U.S. 705 (1977); *West Virginia Bd. of Educ. v. Barnette*, 319 U.S. 624, 636-37, 642 (1943).

In any event, affirmance of the decision below works no improper judicial encroachment into the state legislative domain. The Court in *Casey* permitted states to enact rules governing previability abortion so long as these do not impose an undue burden on the woman's ability to make her decision. 505 U.S. at 872-79. The Court in *Cruzan* expressed great deference to a state's procedural effort to assure competence and voluntariness. 497 U.S. at 280-82. Thus, the Ninth Circuit properly recognized that the State can adequately regulate to protect its legitimate interests here as well.²⁹ 79 F.3d at 816, 833, 837; Pet. App. A-63, A-104, A-112.

²⁹ It is not "improper legislating" for a court to note that simple regulatory protections (waiting period, information on alternatives, second opinion) would safeguard any legitimate interests. Model regulations incorporating these and other safeguards have been proposed. *See, e.g.*, Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119 (1994); Brief Amici Curiae of State Legislators in Support of Respondents (describing various legislative proposals). Many of the interests raised by the State's amici have not been asserted by the

II. SECTION 9A.36.060 DENIES EQUAL PROTECTION TO COMPETENT, TERMINALLY ILL ADULTS WHO ARE NOT ON LIFE SUPPORT

The Ninth Circuit did not reach the question whether Section 9A.36.060 denies equal protection, 79 F.3d at 838; Pet. App. A-115, although it could discern no "ethical or constitutionally cognizable" basis upon which to distinguish between physician assistance by prescribing life-ending medication and the act of withdrawing life support. *Id.* at 821-24; Pet. App. A-75 to A-82. The question was fully briefed and argued below and offers an alternative basis upon which this Court can and should affirm the judgment. *Washington v. Confederated Bands & Tribes of Yakima Indian Nation*, 439 U.S. 463, 476 n.20 (1979). Equal protection did form the basis of the Second Circuit's judgment in *Quill*. 80 F.3d at 727. To avoid duplication of the full briefing submitted in No. 95-1858, the discussion here focuses on the specifics of Washington statutory and case law.

Even before *Cruzan*, the Washington Supreme Court recognized the right of a competent, terminally ill adult to hasten death by directing that life-sustaining medical treatment be suspended. *In re Welfare of Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983); *In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re Guardianship of Grant*, 109 Wash. 2d 545, 747 P.2d 445 (1987). The Washington court effectively excluded from the facial coverage of Section 9A.36.060 those who assist in such decisions.

The Washington Natural Death Act, though limited to withdrawal of life-sustaining treatment, explicitly recognizes the same "fundamental right" in "individual autonomy" as

State itself and could be voiced and, subject to undue burden analysis, properly addressed in the legislative process.

that at stake here. Wash. Rev. Code § 70.122.010. "The legislature . . . finds that . . . such prolongation of the process of dying for persons with a terminal condition . . . may cause loss of patient dignity, and unnecessary pain and suffering" *Id.* "The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own health care" *Id.* The State recognized "the dignity and privacy which patients have a right to expect." *Id.*

These interests and rights apply equally to all mentally competent, terminally ill adults. The statute specifically allows those terminally ill adults who are on life-sustaining treatment to direct their doctors to withdraw such treatment, Section 70.122.030, and it protects such doctors from civil and criminal liability without specifically mentioning Section 9A.36.060. Wash. Rev. Code § 70.122.051. The statute also provides that it "shall not be construed as providing the exclusive means by which individuals may make decisions regarding their health treatment, . . . nor limiting the means provided by case law more expansive than [the statute]." Wash. Rev. Code § 70.122.910.

The State does not dispute that Washington law recognizes a fundamental liberty interest or that it then distinguishes between those competent, terminally ill adults whose condition requires life-sustaining treatment and those whose condition does not. The first group has the right to direct the course of treatment with the specific purpose and result of hastening death. The second group does not, and must suffer the very same pain and suffering and loss of dignity and privacy from which the statute and common law protect the first group.

Under the current arbitrary and irrational scheme imposed by the State of Washington, patients on life support may choose death, even if they are not suffering, and despite any

risk of error of misdiagnosis of condition or competency. Terminally ill patients not on life support are prohibited from surrendering the few days or weeks they have left, even if they must endure them in extreme and unrelenting pain and suffering. The State has never provided any justification for this discrimination — not on the face of the statute, not in the legislative history, and not even as a matter of litigative hindsight.

The State's argument, that the common law right to be free from bodily invasion applies only to the first group, is refuted by the State's admission that the common law was only one of the "underpinnings" for protecting the first group's liberty. Brief for the Petitioners at 43-44. The State does not deny that the other underpinnings, liberty and self-determination, were more important, as is apparent from the express legislative findings in Wash. Rev. Code § 70.122.010. Furthermore, the case upon which the State relies as to the common law in Washington, *Colyer*, not only recognized the liberty of "an adult who is incurably and terminally ill" under both the federal and state constitutions, but held that such a right "encompasses the right to refuse treatment that serves only to prolong the dying process, given the absence of countervailing state interests." 660 P.2d at 742 (emphasis supplied). Only later in its opinion did the court turn to the "common law right to be free from bodily invasion [as] an alternative basis." *Id.* at 743. Thus, the right in Washington is not limited to the refusal of treatment, and the purpose is not just in avoiding battery. The purpose, as here, is avoiding futile, painful, and degrading prolongation of the dying process.

The State's other argument in support of this arbitrary distinction is purely circular. The State says that "one who intentionally acts to cause or contribute to another's death, is with rare exceptions, guilty of criminal conduct." Brief for the Petitioners at 44. Honoring the liberty and the wish to die of a competent, terminally ill patient by withdrawing life support is

one of those rare exceptions. As the Washington Supreme Court held in *Colyer*, the challenged statute does not apply to "the exercise of a constitutional right." 660 P.2d at 751. The question is how honoring in a slightly different fashion the same liberty and same wish of another competent, terminally ill patient is any different. The State has no answer.

The State cites to various state court decisions holding that directing the withdrawal of life support is not suicide and that assisting the patient in removing life support is not assisted suicide. Brief for the Petitioners at 37. Proving that Washington and other states make a distinction does not prove that the distinction is justified. That these courts felt a compulsion to create an exception to their assisted suicide statutes for physician withdrawal of life-sustaining technology confirms traditional respect for patient autonomy, especially at the end of life, but it hardly means that the legislatures that enacted the statutes subscribed to any purposes that would distinguish between dying patients. The act of a dying, suffering patient choosing to shorten the period of suffering before death by consuming life-ending medication is no more suicide in the traditional or typical sense than is withdrawal of life support. In both, the only question is the manner, not the fact, of taking action to hasten death when death is impending. Continuation of life is not a choice for these patients.

Some of the State's amici contend that the discriminatory treatment is justified by the difference between an act and an omission. Withdrawal of life support, they say, is somehow not an act, though it requires activity. Terminal sedation does not cause death, they believe, though it requires the administration of medication to induce and maintain sedation until death inevitably occurs. The State certainly would not adopt this distinction, and apply it in this way, if, for example, a hired killer removed a respirator or induced a coma and cut off nutrition and hydration. Is the State itself immune if its jailers "omit" to feed prisoners, and they die? In fact, the

writing of a prescription is less active than the removal of a gastrostomy tube. *Quill*, 80 F.3d at 729. If this distinction were the critical factor, the right to direct withdrawal of life support would not be limited to terminally ill patients. The action/inaction distinction, rejected by Justice Scalia in *Cruzan*, 497 U.S. at 296-97, exists only in the minds of those who wish to *preserve the appearance* that they are not participating in hastening death. *Compassion*, 79 F.3d at 821-22; Pet. App. A-75 to A-78. This basis cannot support such discrimination.

Nor is a distinction found in the fact that a patient on life support might feel a "captive" of that type of care. See Brief for the Petitioners at 42 (citing *Cruzan*, 497 U.S. at 288). As discussed in the Brief of Respondents in No. 95-1858, a dying, suffering patient, whose life and dying process have been extended by modern medical technology, but who is not presently on life support, similarly becomes a captive of her disintegrating body and the medical care that brought her to that juncture. See Brief Amici Curiae of Bioethics Professors Supporting Respondents. This patient has the identical motivation and objective as the patient whose condition happens to encompass life-sustaining technology: the desire to hasten impending death in a humane and dignified manner.

Thus, as properly recognized by the District Court in this case, which did reach the equal protection claim, the decision to request termination of life-sustaining treatment to hasten death is different in no material respect for a terminally ill patient from requesting life-ending drugs. *Compassion*, 850 F. Supp. at 1461, 1466-67; Pet. App. E-15, E-25 to E-28. The same conclusion was reached by the Second Circuit in *Quill*, 80 F.3d at 729.

Having recognized a liberty — indeed, a "fundamental" liberty — in determining whether to endure a prolonged dying process, the State may not deny it to one group of patients,

particularly where regulation can achieve any legitimate state interests, interests that apply equally to both groups. The Court should affirm the judgment below because the statute impermissibly burdens liberty and denies equal protection.

CONCLUSION

The Court has long recognized that the constitutional right of liberty stands as a barrier against laws that deny individuals the right to make the most fundamental choices affecting their values, their bodies, and the course of their lives. The Constitution protects the liberty of a dying citizen to choose how to die in accordance with her own intensely personal convictions. The private values that inform this decision are too central to personality, too much at the core of liberty, to allow the State to decide how everyone must act or what everyone must believe.

The Ninth Circuit correctly applied the Court's precedent in finding that the Fourteenth Amendment protects the liberty of competent, terminally ill citizens to determine their moment of death and to do so in a manner that comports with values formed over their lifetime, while at the same time recognizing the legislative role in crafting safeguards to protect legitimate state interests. Respondents urge the Court to remain true to principled application of precedent and once again define the freedom guaranteed by the Constitution's own promise, the promise of liberty, and affirm the judgment below.

The Court should also, or alternatively, affirm on the ground that the challenged law violates the Equal Protection Clause. Having recognized a liberty to choose to die in a dignified manner with limited pain and suffering, the State may not preclude some individuals from exercising that liberty.

Respectfully submitted,

Kathryn L. Tucker
Counsel of Record

David J. Burman
Kari Anne Smith
PERKINS COIE
1201 Third Avenue, 40th Fl.
Seattle, WA 98101-3099
(206) 583-8888

Of Counsel
Laurence H. Tribe
Hauser Hall 420
1575 Massachusetts Avenue
Cambridge, MA 02138
(617) 495-4621

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Attorneys for Respondents